Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation of Health and Social Care Services

Overview Report on the Thematic Programme of Inspection of Foster Care Services 2021 - 2022

December 2023

Safer Better Care

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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About the monitoring of statutory foster care services

The Health Information and Quality Authority (HIQA) monitors services used by some of the most at-risk children in the state. Monitoring provides assurance to the children, their families and the public that children are receiving a service that meets the requirements of quality standards and where the service falls short of the acceptable standard, the provider is held to account and required to take action. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring foster care services also has an important role in driving continuous improvement so that children have better, safer services.

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under Section 69 of the Child Care Act 1991, as amended by Section 26 of the Child Care (Amendment) Act 2011, to inspect foster care services provided by the Child and Family Agency (Tusla) and to report on its findings to the Minister. HIQA administers this function through the Chief inspector and the Children's team. Foster care services are monitored against the *National Standards for Foster Care*, published by the Department of Health and Children in 2003.

In order to promote quality and improve safety in the provision of foster care services, HIQA carries out inspections to:

- assess if the Child and Family Agency (Tusla), the service provider, has all the elements in place to safeguard children
- seek assurances from service providers that they are safeguarding children by reducing serious risks
- provide service providers with the findings of inspections so that service providers develop action plans to implement safety and quality improvements
- inform the public and promote confidence through the publication of HIQA's findings.

HIQA inspects services to see if the national standards are met. Inspections can be announced or unannounced. HIQA would like to thank children, parents, foster parents and staff for their engagement with the inspection process.

Profile of the foster care service

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children, Equality, Disability, Integration and Youth. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

Tusla has responsibility for a range of services, including:

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- domestic, sexual and gender-based violence services.

Child and family services are organised into 17 service areas and are managed locally by area managers. The areas were grouped into four regions, each with a regional manager known as a service director. Early in 2023 Tusla reconfigured the four regions into six regions, and restructured the management of them, they are now managed by regional chief officers. The regional chief officers, like the service directors, report to the national director of services and integration, who is a member of the national management team.

HIQA inspects all 17 service areas. Tusla also places children in privately run foster care agencies and has specific responsibility for the quality of care they receive.

Tusla reported that, at the end of Quarter 2 2023, a total of 5,595 children were in care, of which 5,067 (91%) of children in care were in foster care (general, relative and supported lodgings). Of these, 79% (4,447) of children in care had an allocated social worker.[1]

[1] Tusla Quarterly Service Performance and Activity Report, Quarter 2 2023

1. Introduction and background

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of people receiving services. They assess compliance against the relevant national standards, in this case the *National Standards for Foster Care* (2003). As this thematic inspection programme was focusing on service quality improvement, only those areas deemed to have previously had a high level of compliance with standards were included in this inspection programme. The Health Information and Quality Authority (HIQA) selected 13 service areas to inspect under this programme. All other areas continued to be monitored and inspected in line with our risk-based monitoring approach.

This thematic inspection programme was focused on assessing the efficacy of governance arrangements across foster care services and the impact these arrangements had for children in receipt of foster care. This thematic programme was the third and final phase of a three-phase schedule of inspection programmes monitoring foster care services.

This thematic programme was carried out throughout 2021 and 2022 and the following standards were reviewed as part of this programme:

- Standard 18: Effective policies
- Standard 19: Management and monitoring of foster care services
- Standard 20: Training and qualifications
- Standard 21: Recruitment and retention of an appropriate range of foster carers
- Standard 22: Special foster care
- Standard 23: The foster care committee
- Standard 24: Representations and complaints.

This report provides a summary of the key findings from these 13 thematic inspections, highlights learnings for The Child and Family Agency (Tusla) and outlines HIQA's plan for further monitoring of foster care services.

The 2017 to 2018 foster care inspection programme, Phase 1, focused on the recruitment, assessment and approval of foster carers, foster care reviews, support, supervision and training of foster carers, including the arrangements in place for safeguarding and child protection.

The 2019 to 2020 inspection programme, Phase 2, focused on the arrangements in place for the assessment of need for children in care, and the care planning and

review process, including preparation and planning for leaving care, matching carers with children, and safeguarding.

2. Overview of the thematic programme methodology

As this was a thematic programme, HIQA developed with the support of the Advisory Group, and feedback from key stakeholders, a specific Guidance and Assessment Judgment Framework. The guidance was published on the HIQA website. Not all service areas were included in the thematic programme as some services had poorer levels of compliance. Those areas not included in this thematic programme were monitored and inspected in line with our risk-based monitoring approach.

A self-assessment questionnaire (SAQ) is part of the suite of tools developed for a thematic programme. The SAQ was issued to the 13 Tusla service areas at the start of the programme. Each service area was required to complete the questionnaire using the guidance and assessment judgment framework document, which described what a good service looked like, to review their own service. Completed SAQs were submitted to HIQA.

On the completion of the self-assessment questionnaire, each Tusla service area was asked to develop a quality improvement plan to address any deficits identified. Inspectors viewed this plan and progress made on its implementation during the inspections.

In 2021, a total of six Tusla service areas were inspected, and the remaining seven service area inspections were completed in 2022.

As part of the thematic programme of inspections, inspectors met with managers and staff involved in delivering services to children in foster care, children in care, parents and with foster carers.

In line with the focus of the thematic programme, HIQA inspectors reviewed:

- the policies in place to promote the provision of high-quality foster care service
- how effective the management and monitoring structurers were
- how well trained and suitably qualified staff employed to work with children, their families and foster carers were
- the recruitment and retention strategies in place
- the provision of a foster care service to support the particular needs of children with complex or additional needs

- the functioning of the foster care committee
- the arrangements in place for children placed with private foster care agencies
- the management of representations and complaints.

The key activities of each of these inspections involved:

- the observation of practices
- the analysis of data submitted by the area
- meeting with or speaking to children in care
- telephone calls and or meetings with parents of children in care
- interviews and meetings with area managers, principal social workers and other managers
- interviews of focus groups with external professionals such as advocacy organisations or guardians-ad-litem[2]
- separate focus groups with children-in-care social workers, fostering social workers, and with foster carers
- the review of the relevant sections of the files of children in care as they relate to the focus of the inspection
- the review of documentation relating to the areas covered by the relevant standards.

[2] A guardian ad litem refers to an individual appointed by the court to represent the best interests of a minor child in legal proceedings.

3. Executive summary

Overview of findings

Good governance and management systems are important to ensure the delivery of a safe and effective foster care service.

Overall, this thematic programme found that Tulsa had put a significant focus on strengthening and further improving governance arrangements for the delivery of services to children in foster care. In addition, all service areas had appropriate structures in place and clear lines of accountability. However, some service areas' governance arrangements were more effective than others, due to risks identified in these service areas. As the programme progressed, inspectors found that there was a lack of strategic governance and oversight from Tusla at national level in response to the emerging and increasing risks, as outlined by the collective finings in this report.

This thematic programme found that there was a deterioration in compliance with standard 19, management and monitoring in 2022, in comparison to 2021, with five of the six areas inspected in 2022 judged moderate non-complaint. In addition, there was a high level of non-compliance with Standard 21: Recruitment and retention of foster carers, across the two years, with a total of seven areas being assessed as moderate non-compliant with this standard.

The thematic programme highlighted the urgent need for Tusla at national level to proactively provide a strategic response to the risks which were escalating and known to them at the time. Priorities in this regard related to:

- A national approach to the management of unallocated cases and the growing number of unallocated children in care
- A national approach to the provision of an adequate, equitable and well-supported foster care service to children with complex needs
- A national approach to quality assurance across all service areas
- Specific, measureable, actions in relation to the implementation of the Strategic Plan for Foster Care Services for Children and Young People 2022-2025.

Some service areas achieved high levels of compliance during this thematic programme with Mayo, Donegal, Galway Roscommon and the Midlands achieving compliance or substantial compliance across all of the standards. Inspectors found that the three areas within the West region had systems in place to share learnings from HIQA inspections and collaborate with each other about improvements. In addition, two further areas also had high levels of compliance, with Dublin South

Central and Dublin North mainly achieving compliance and substantial compliance and only having one moderate non-compliance. Dublin North City thematic inspection could not proceed due to significant risks and a risk-based inspection was carried out.

The remaining seven service areas had between two and four moderate non-compliances, with the poorest performing areas being Waterford Wexford and the Midwest.

Staffing and the recruitment of foster carers, despite the efforts of many service areas, remained a challenge. This highlighted the need for improvement with regards the capacity and capability of their services, in order to provide a safe and effective service for children and foster carers. Increased pressures on the capacity of service areas to, in the first instance, attract, then recruit, assess and retain foster carers meant that service areas' contingency plans and risk management processes were stretched, at times beyond capacity.

The recruitment of foster carers continues to be an issue in some service areas, and despite significant recruitment initiatives, service areas continue to struggle to ensure that there are adequate suitable placements for children in care in their areas. The majority of service areas were reported as not having a sufficient number of foster carers, reflecting the national shortage of foster carers within the Tusla system.

This issue must be reviewed and a national plan put in place to manage these risks, and ensure that improvement plans are comprehensive, and that control measures put in place to mitigate the risks are achievable, and constantly monitored by Tusla in order to ensure that all children in foster care receive a good-quality service. In 2022, Tusla published its Strategic Plan for Foster Care Services for Children and Young People 2022-2025 which outlined their ambitions for the next three years. HIQA welcomes this plan as it addresses some of the areas of improvement identified by the thematic inspection programme. However, it does not adequately address the urgent areas of risk. For example, it recommended the recruitment of a national lead for fostering and a review of the structures in place for the assessment and recruitment of foster carers at a regional level. While both of these are welcome recommendations, these will not have an immediate impact on the deficits identified already during 2022.

Tusla's strategic plan has committed to increasing their statutory foster care provision by 2025; however, there is need for yearly metrics by which Tulsa can measure the implementation of the action. In addition, the plan recommended that it will implement a consistent model of practice in foster care services, strengthen its

organisation's structures to better support its staff and to strengthen its support to parents whose children are in care, but it does not set out how it intends to do this.

All service areas had developed service improvement plans, and most service areas knew what their identified areas for improvement were and they had plans in place to address them. All service areas inspected demonstrated a real commitment to promoting quality improvement in their respective areas. However, the effectiveness of services areas' plans was reliant on the capacity of the service areas to implement them in practice. Some service areas' plans did not effectively identify and target some of the unique challenges and risks identified for their foster care service in the previous 12 months.

Despite these plans, increased pressures on Tusla to recruit and retain staff, and insufficient social work graduates, impacted on some service areas ability to meet standards. These difficulties arose even when measures were put in place such as approving vacant posts, as some service areas were unable to fill these posts. Risk factors associated with shortfalls in staffing continued to lead to risks throughout the 2022 inspection programme. These risk factors included children in care without an allocated social worker and a lack of sufficient and suitable placements to meet the needs of children.

Service areas were proactive and put initiatives in place to increase staff retention, such as promoting further education and training and having wellbeing programmes in place. This included access to wellbeing videos which were available to staff during the COVID-19 pandemic. While some service areas had developed training needs analyses to inform their learning and development programmes, some were not up to date and professional development plans were not always in place for staff to promote their learning needs. Senior managers acknowledged the requirement to enhance this in certain service areas to further add to the retention initiatives which were in place for staff.

One response to the staffing deficits on children-in-care teams was to assign social care workers to children in care when they did not have an allocated social worker. During the 2021 inspections, two service areas were found to be assigning social care workers to undertake some tasks with unallocated children in care, and in the 2022 inspections four of the service areas inspected had put this process in place. The unallocated case procedures set out the expectation that social care workers or social care leaders managed unallocated cases in the absence of an allocated social worker, and would receive monthly supervision of their caseload from a social work manager. Inspectors found that although supervision was mostly regular, it was not always in line with the expected frequency or standard as set out in Tusla's supervision policy. Given that in six service areas social care workers were

undertaking the work usually assigned to a social worker, this oversight was critical to ensure the safety and quality of service provided to children in the care of Tusla.

While such systems ensured essential tasks were completed, such as maintaining contact with families, there was growing pressure on team leaders to balance case management responsibilities and adhering to national standards, with their wider governance and service development priorities. In addition, there was no nationally agreed framework developed to determine what cases could be assigned to a social care worker, and what type of work they could complete, and what cases required specific social work expertise.

All service areas provided a good service to children with complex needs who required more specialist services. However, the provision of a 'special foster care' service was not supported by the required Tusla national policies and procedures, and, therefore, the practice varied between service areas in relation to the level of supports they provided to foster carers caring for children with complex needs. The lack of overall governance of this area meant that that there was an inequitable provision of enhanced payments and supports to foster carers throughout the country, as service areas did not all follow the same guidance.

Well-governed services have clear policies which are consistently implemented and this ensures that children receive consistent and effective services. When followed fully, nationally implemented policies, procedures and guidance should lead to consistent practice. Overall, improvements were required by Tusla to ensure that policies and procedures were effectively implemented and adhered to consistently in each service area. Due to gaps in national policy, inspectors found that several areas had developed their own local policies and procedures to manage situations, which led to differing practice around the country. This meant that service provision for children and foster carers varied depending on what approach was taken by each service area. In addition, Tusla had no process in place to review locally developed policies and standard operating procedures (SOPs) to ensure they aligned with best practice, standards and regulations. Furthermore, service areas often developed them in isolation from the national office. The most significant instance was of guidance being developed in one service area for the approval of additional funding and supports for foster carers caring for children with complex needs. The development of local policies in this instance meant that Tusla was not delivering an equitable service to all children with complex needs.

While there were improvements in many service areas in relation to oversight of key practice, and several examples of good initiatives, the opportunities to create further consistency across the service areas were not taken and still required development. For example, some areas had developed their own systems for tracking key performance indicators, such as statutory visits to children in care. However, these

had been developed in isolation and, as a result, each service area had different tracking systems.

Well-governed and well-managed services had learned from previous HIQA inspections, had transferred the learning from other service areas, and carried out their own internal auditing processes to improve their service. As outlined above, this was notable in the service areas in the West region. However, it was not consistent in all areas. This is a significant step in ensuring that the services provided by Tusla to children in care are consistent and equitable.

The variance and inconsistent practice that was evident throughout the 2021-2022 inspection programme, highlighted the lack of national oversight of quality assurance systems across all service areas. The significant message received from children in care was that when they had a long-term stable social worker, they received a good service. The majority of children spoke highly of their social workers and foster carers. However, not all children in care had an allocated social worker. Some children had experienced several changes in social workers, some had not yet met their social worker, and it had been some time since others had seen their social worker.

HIQA's Phase 1 overview report published in 2019 identified that, throughout the thematic monitoring programme in 2017 and 2018, it became apparent that similar findings were arising in each service area. Despite these being highlighted early in 2017, the same findings were still evident in the 2018 inspections. Phase 1 found little consistency across service areas and practice varied in service areas within a region. The lack of shared learning and development of common systems across the country, within regions and between regions, was noted as far back as 2019 in the variety of different systems that had been set up nationally.

Further work is required by Tusla to continue to raise compliance with the *National Standards for Foster Care* across and within the services areas.

4. Compliance classifications

HIQA judges the service to be **compliant, substantially compliant,** or **non-compliant** with the standards. These are defined as follows:

Compliant	Substantially Compliant	Moderate Non-Compliant	Major Non-Compliant
A judgment of compliant means that no action is required as the service has fully met or has exceeded the standard.	A judgment of substantially compliant means that some action is needed in order to meet the standard. The action taken will mitigate the non-compliance and ensure the safety, health and welfare of the children using the service.	A judgment of moderate non-compliant means that substantive action is required by the service to fully meet the standard. **Priority action** is required by the provider to mitigate the non-compliance and ensure the safety, health and welfare of children using the service.	A judgment of major non-compliant means that the service has not met the standard and may be putting children in risk of harm. **Urgent action** is required by the provider to mitigate the non-compliance and ensure the safety, health and welfare of children using the service.

5. What children, parents and foster carers told us

What children told us

This section of the report builds on children's views and experiences shared within the previous Overview Report - Monitoring and regulation of children's services in 2022.[3] Positive feedback and areas for improvement are outlined and expanded on within later sections of this report.

As part of the inspections completed across 2021 - 2022, inspectors engaged with a total of 90 children and young people in foster care. They participated in a number of ways that included speaking directly with an inspector during an inspection, over the phone or by completing and returning a survey.

[3] Report published here: Overview Report: Monitoring and Regulation of Children's Services 2022

Most children who spoke with inspectors were living in stable foster care placements, and had an allocated social worker at the time of the inspection. These two features contributed to enabling children to experience safe care, to enjoy and achieve and report high levels of satisfaction with the service. They are important indicators of whether a service is sufficiently well led and resourced. Children less satisfied with the quality of the service were more likely to have experienced turnover of social workers, not to have an allocated social worker, or their placements were at risk of, or had broken down.

Children spoken with said they felt safe and were happy with where they lived and the care provided by their foster carers. They understood why they were in care. Children told inspectors about sensitive ways such information had been shared with them through storytelling and collecting memorabilia. Children spoke about having fun and being helped to enjoy their childhood. They spoke about their achievements and the help they received to do well at school, or in sports and music. They reported having good friends and being able to see their parents, brothers and sisters.

Overall, feedback from children about their allocated social worker was mostly positive. Children who did not have an allocated social worker, generally said they had a social care worker to check how they were getting on. Children were generally aware of the role of their social worker or social care worker and how they could help them. They said some workers were creative in their approach to getting to know and spend time with them. Children said they felt comfortable talking to them and recalled nice experiences they had shared together such as playing football, attending an art event or having lunch together.

They felt able to talk to them if they had any worries or concerns.

Positive feedback included:

"I feel comfortable with her, if I am upset, she checks that everything is okay"

"My worker is nice. I see them every couple of months. Sometimes they take me out on my own and we sit and talk together".

"She has helped me with everything I need. I can contact her if I have any worries or complaints"

One child spoke about their experience of making a complaint and said:

"It was the first time I felt listened to. It is important. Kids views count."

The majority of negative feedback related to poor frequency of contact, not having a social worker or frequent changes of social worker:

"I do not want to have more changes of social worker"

"My social worker barely rings or texts"

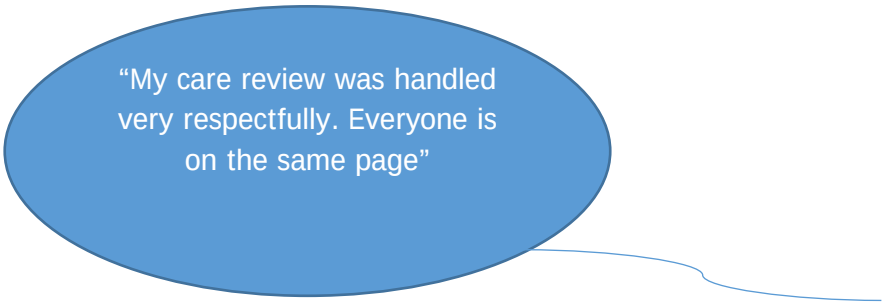
"Social workers could check in more to see if everything is ok"

A few children said they did not have a social worker which meant they were not always sure about the decisions that were being made for them. They said they did not know about their care plan or how to make a complaint. One child compared their experience when they had a social worker to now not having one:

"They used to visit me and ask my views about my care plan and I was invited to my child-in-care reviews. I have not been visited since my last social worker left and I am not sure about my future plan."

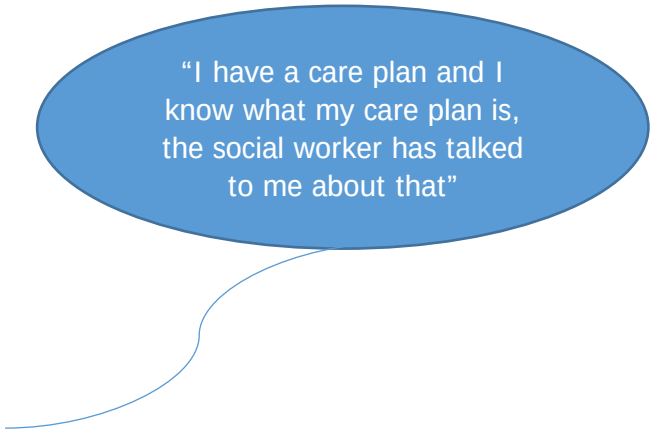
Children's levels of participation in meetings where decisions were made about their care varied. Their attendance seemed to relate to the level of support that was available to support their involvement. The Midlands service area stood out as particularly child centred and inclusive in its approach in valuing children's feedback and had a number of participation groups in place. They provided children with a 'backpack' when they were received into care, which included comforting items to help them settle in to their placements.

Some children said that while they completed their own Teenagers and Children Talking in Care (TACTIC)[4] review form, they had not received feedback regarding the outcome. Where children had been supported to participate in their meetings, their experience was generally positive:



Other children said they chose not to attend their review meeting, as this was what suited them. A few children who had attended, however, said they had not felt listened to at their meeting.

Children reported mixed experiences overall of their awareness of their care plan and this being discussed with them by their social worker. Some told inspectors they did not receive any paperwork after the meeting and did not have a copy of their care plan. Others spoke about good support from their social worker in understanding their future plan:



[4] Tusla's review form 'Teenagers and Children Talking in Care' used nationally for obtaining the views of children about the things that mattered most to them for consideration in their statutory review.

Most children spoken with were in settled foster care placements, going on to say that they felt like one of the family. However, one child with experience of moving between different foster placements said:

> "Tusla needs to make sure social workers are listening to children and that they are making the right choices about where to place them."

Tusla's new national initiative to provide backpacks to children in care was praised, and children commented positively on the items of comfort and encouragement provided by other children in helping them settle into their new homes.

> "Tusla is a great service for children in need. I've been very lucky. I've had a really good experience."

Overall, while most children spoke positively about their experience of the fostering service, they also identified important priorities for improvement that will be further considered in later sections of this report. These include:

- Making sure all children in care have a named and consistent social worker to help them throughout their childhood and to support them to navigate through their care experience
- Dealing quickly with delays and waiting lists for services that are important to children's wellbeing and development
- Providing more information about children's rights and services, including aftercare services
- Ensuring children are encouraged at every possibility to participate in decisions about their lives, and attend and contribute to their child-in-care reviews
- Keeping them informed and involved, explaining important events and decisions, including their care plans and aftercare plans.

Although children's recent feedback is similar to the findings presented in the *Overview Report - Monitoring and Regulation of children's services in 2022*, children overall reported seeing their social worker less frequently than had been the case previously. In addition, they said less about their rights and how their background and culture was reflected in their care arrangements. These areas are being considered in more detail in HIQA's 2023 statutory foster care inspection programme and will be reflected in next year's overview report.

What parents told us

Parents overall reported mixed views of their experience of working with Tusla. While generally they were assured that their children were well cared for and happy,

others reported feeling left out of, and were not informed of decisions being made about the future care of their children. Some parents reported difficulties in contacting a social worker, and some thought the service could be better at keeping them informed about their progress and changes. Most said they were invited to attend their children's reviews, and some said they had been listened to and felt supported. This included individual social workers taking the time to help them to understand their child's care plan. While some parents said they knew how to make a complaint, others were not aware of how to do so. In a few cases, they said the issues they had complained about had been ignored.

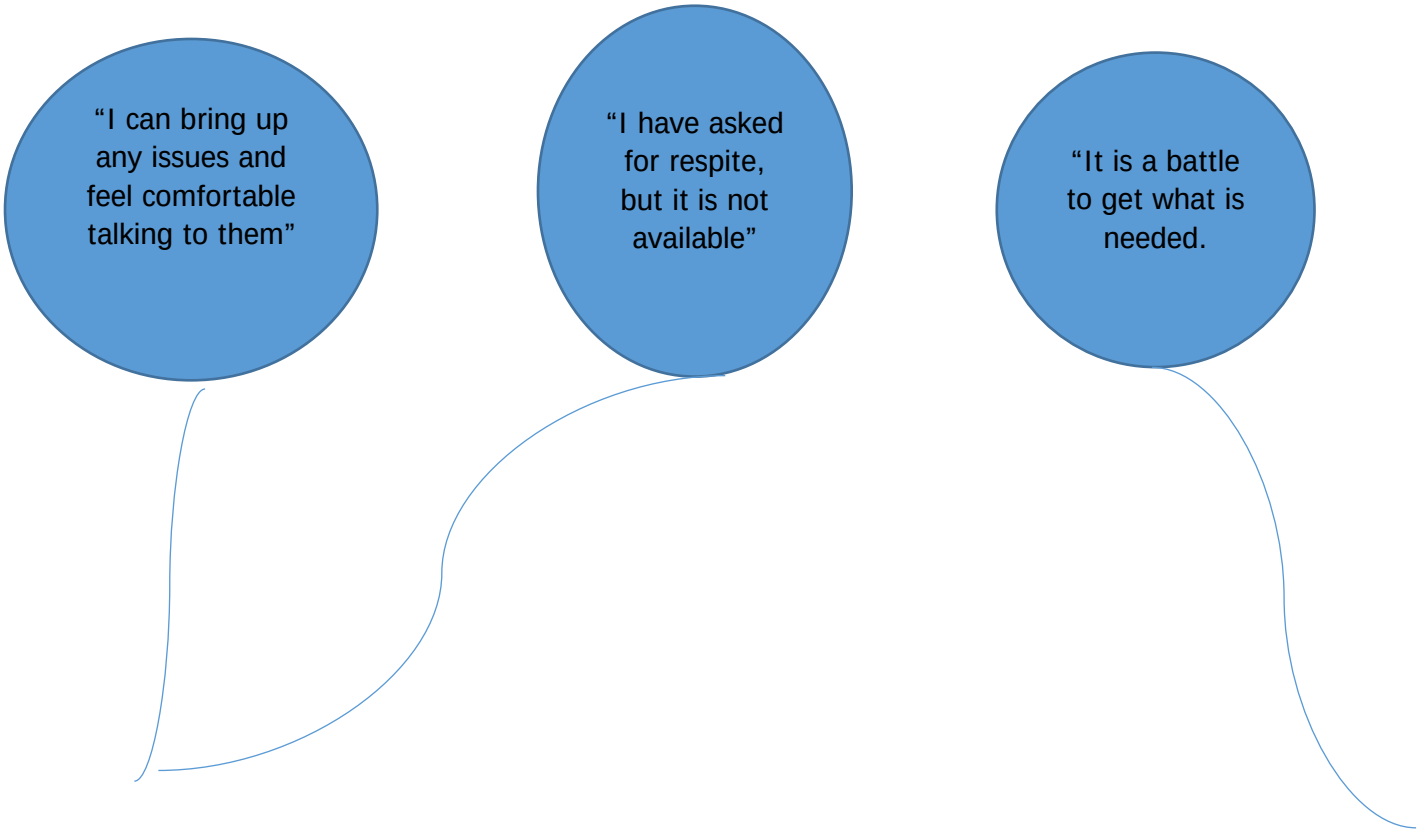
What foster carers told us

Foster carers who spoke with inspectors were mostly satisfied with the support they received from their local fostering teams, but also raised concerns about the children's levels of contact with, and turnover of their social workers. Most felt sufficiently involved in meetings, including child-in-care reviews. Foster carers spoke about the continued shortfalls in foster carers in their area, and that they were increasingly approached to take more children at short notice. They reported mixed experiences of the extent to which they had been consulted and involved in helping to shape service improvements. Most foster carers were aware of relevant Tusla policies and procedures and their attendance at mandatory training was encouraged. Most were also aware of how to make a complaint.

They valued the return to face-to-face contact with their social worker and local foster care groups which had been paused due to COVID-19 restrictions.

The inspections towards the end of the inspection programme identified an increase in foster carer dissatisfaction levels, including their recognition and the levels of support available to them. This included the availability of fostering social workers and their access to respite care, as well as the level of fostering payments. Some foster carers reported their experience of delays in assessments or support from other agencies in caring for children with disabilities or complex needs including

mental health concerns. These issues indicated the need for a more strategic national response in terms of retaining foster carers, work to further strengthen their expertise and the development of special foster care provision.



6. Summary of focused inspection findings 2021 – 2022

This chapter provides a summary of the findings of the programme of thematic inspections and the extent to which the service area met the relevant *National Standards for Foster Care*, 2003.[5] This inspection focused on effective policies, the management and monitoring of the service, training and qualifications of staff, the recruitment and retention of foster carers, the arrangements in place for special foster care, the foster care committee, placement of children in private foster care placements, and representations and complaints.

Tusla has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Good governance is essential to delivering a safe and effective foster care service. In a well-governed service, overall accountability for the service is clearly defined and the governance arrangements ensure a safe, sustainable service is delivered within a child-centred culture. Good governance of foster care services is essential to ensure that children receive a high-quality service which is safe, consistent, equitable and well supported by social workers. Services must be well governed in order to achieve compliance with standards. This programme of inspections focused mainly on the governance of the service in order to determine how effective and safe the service being provided was.

While this thematic programme found that individual service areas had good governance structures in place, and were striving for quality improvement, other service areas struggled due to the specific risks and challenges that they faced, as mentioned earlier in relation to resources, specifically in relation to recruiting and retaining both social workers and foster carers. Variations in practice and the absence of national policies on core issues such as special foster care, resources for children with complex needs, management of unallocated children in care and the arrangements in place for social care workers to be assigned tasks previously assigned to social workers, meant local initiatives were often put in place, leading to inequity in service provision across the country.

Thirteen Tusla service areas were inspected as part of this programme. A further service area inspection of the Dublin North City service area was commenced under this programme, however, due to risks identified, it changed to a risk-based inspection during the course of our inspection and therefore is not included in this overview report. The Carlow/Kilkenny/South Tipperary service area was included in the programme instead, as they had demonstrated progress and were deemed to now be eligible for inclusion in the programme. Non-compliances were found in eight

[5] Judgments were made against four descriptors: Compliant; Substantially compliant; Non-compliant – major; Non-compliant – moderate.

of the service areas, namely Midwest, Carlow/Kilkenny/South Tipperary, Dublin South East/Wicklow, Waterford/Wexford, Louth/Meath, Dublin South Central, Cavan/Monaghan, and Sligo Leitrim/West Cavan. A good level of compliance was noted in the other five areas, Mayo, Donegal, Galway/Roscommon, North Dublin and the Midlands. All areas performed well in relation to their compliance with Standard 20: Training and qualifications. While the poorest compliance was found for standards on management and monitoring, with eight service areas non-compliant, and recruitment and retention of foster carers, with seven areas non-compliant.

6.1. Standard 18: Effective Policies

Standard 18: Effective Policies

Health boards have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it.

Judgment	No of Areas	Service Areas
Compliant	**1**	**Donegal**
Substantially Compliant	**8**	**Mayo** **Sligo, Leitrim and West Cavan** **Galway and Roscommon** **Dublin South Central** **Carlow, Kilkenny and South Tipperary** **Midlands** **Dublin North** **Dublin South East/Wicklow**
Non-compliant Moderate	**4**	**Cavan Monaghan** **Louth Meath** **Mid West** **Waterford andWexford**
Non-compliant Major	**0**	

Well-governed services have clear policies which are consistently implemented ensuring that children receive consistent and effective services. When followed fully, nationally implemented policies, procedures and guidance leads to consistent practice. Overall, improvements were required by Tusla nationally to ensure that policies and procedures were effectively implemented and adhered to. Positively, national policies, procedures and guidance were aligned to relevant legislation, regulations, policies and standards. While Tusla had a system for nationally

approving policies with dates for reviewing them, there were gaps in national policies and procedures. Due to these gaps in national policy, several areas developed their own local policies and procedures to manage situations, which led to differing practice around the country. This meant that service provision for children and foster carers varied depending on what approach was taken by each service area. In addition, Tusla had no process in place to review locally developed policies and standard operating procedures (SOPs), to ensure they aligned with best practice, standards and regulations, and service areas often developed them in isolation from the national office. There was little evidence that service areas escalated the absence of specific policies or SOPs to Tusla at national level so that the gaps in guidance could be addressed.

One service area was compliant, eight were substantially compliant and four were moderate non-compliant with this standard. There were areas of good practice as well as areas of improvement identified in each of the service areas.

In 2021, as a result of the COVID-19 pandemic, Tusla had implemented and reviewed their national policies and guidance documents and all areas had systems in place to ensure that staff were kept up to date with these changes.

All of the service areas had management systems in place that ensured that the national policies, procedures and guidances that were in place were known to staff and were guiding staff when implemented fully to provide a consistent practice with children and foster carers. There was good dissemination of these national policies, and good communication systems in place to ensure staff were kept up to date on national policies. Staff had a good understanding of national policies. There was evidence of the provision of child-centred services, good partnership approach with children and foster carers, and joint working, although the level of development in these areas varied between the service areas.

However, there were gaps in the full implementation and adherence to some policies, and national policies did not address all of the areas of practice required. As a result, service areas often developed their own local policies or guidance in order to inform their practice.

Developing policies in isolation from nationally agreed policies, without the approval of Tusla at national level, is poor governance practice. This led to differing practices, and service provision, when throughout all service areas there should be consistency.

An example of this was in Dublin South Central, whereby the service area had developed their own guidance document for staff when considering enhanced payments for foster carers, in the absence of a nationally agreed policy. While this meant there was a clear guidance for staff in this service area, it also meant that

there was an inequitable provision of enhanced payments to foster carers, as other service areas did not follow the same guidance.

Inspectors found other examples of implementation of local guidance which had led to differing practices, with one having had a more significant impact. In Cavan Monaghan, local guidance was being implemented to assist staff with managing allegations made by children against foster carers, but which was not in line with *Children First: National Guidance for the Protection and Welfare of Children* (2017) or Tusla's standard business process for managing allegations made by children. The respective service director subsequently provided written confirmation to HIQA that this new guidance would not be implemented in the service area and that all allegations by children in care would be managed in line with Children First (2017). However, this also highlights weaknesses in the governance of local policies at a national and regional level, to ensure they are fully aligned with standards, regulations, and legislation.

One service area implemented a new local policy that addressed the issue of foster carers not receiving support and supervision in line with national standards and regulations, which the service area reported was working well. In another service area they operated a dual process for the recording of information on foster carer's files, which was not in line with Tusla policy. In addition, there was inconsistent practice in relation to tracking and recording of training for foster carers; therefore, in two service areas due to the lack of oversight of key mandatory training, it was found that foster carers required updated training in Children First (2017).

Good practice was noted in the West region in particular, where they had set up a group entitled the 'task and finish' group, comprising all the areas in the region, in order to drive consistency across the region. This was noted during the inspections of Sligo Leitrim West Cavan, Donegal and Mayo. The 'task and finish' group aimed to standardise practice and share learning throughout the region. This meant that all service areas within the region learned from each other, learned from the HIQA inspections within the service areas, and improved consistency in both the implementation of policy and practice within the region. However, whether there was governance of these by the national office was not evident.

A significant risk identified as increasing during 2022 was the growing number of unallocated children in care in some service areas. HIQA therefore looked at the policies and procedures in place to manage these risks. Three of the seven areas inspected in 2022 had introduced a local policy and procedure for responding to the needs of unallocated children in care. While this meant that service areas individually were putting measures in place to manage unallocated children in care, the lack of a national approach meant that practice differed throughout the country. Good oversight was found in some areas, such as Cavan Monaghan, where they had a

tracker in place for child-in-care reviews, which meant that even if children did not have an allocated social worker, their care plans were kept up to date. However, this was not consistent across all areas, and the national office did not have any governance arrangements in place to measure the effectiveness of these local policies and SOPs.

Service areas such as Carlow Kilkenny South Tipperary began to experience significant shortfalls in social workers for children in care, with the number of children in care unallocated rising to 129 (43%) at the time of the inspection, and rising even further since. Louth Meath had 82 children in care unallocated, with 43 of them catagorised as high priority. The service area had appropriately escalated this issue both regionally and nationally, however, the response had not been effective. Dublin North also had 66 children who were unallocated a social worker, some of whom were dual unallocated, a small number were in private foster care placements with no Tusla oversight, and three of whom had been unallocated for over three years. While 40 of these children were allocated to social care workers, no consideration had been given to looking at the whether other areas had the capacity to provide a social work service to these children. Mayo for example had 100% social work allocation consistently. Of the 13 service areas inspected throughout the programme, the variance in allocation of children in care to social workers was significant with five areas having less than 20 children unallocated. Essentially service areas, such as the Carlow Kilkenny South Tipperary, Louth Meath and Dublin North, were operating in a silo from other service areas within Tusla.

In the 2021 inspections, two areas were found to be assigning social care workers to undertake some tasks with unallocated children in care, and in the 2022 inspections four of the service areas had put this process in place. In some areas, the unallocated case procedures set out the expectation that social care workers or social care leaders managed unallocated cases in the absence of an allocated social worker, and would receive monthly supervision of their caseload from a social work manager. Inspectors found that although supervision was mostly regular, it was not always in line with the expected frequency or standard as set out in Tusla's supervision policy. Given that in six service areas they were undertaking the work usually assigned to a social worker, this oversight was critical to ensure the safety and quality of service provided to children in the care of Tusla.

While such systems ensured essential work was delivered in maintaining contact with families, there was growing pressure on team leaders to balance case management responsibilities and adhering to national standards, with their wider governance and service development priorities.

Tusla had a national organisational risk management policy and procedure to guide service areas. Service areas had a 'need to know' system in place, in line with Tusla's

national incident management system and this was used to notify Tusla's national office of serious incidents and adverse events in relation to children in care. Risks were escalated to service directors when further actions were required to address the identified risks. The effectiveness of this policy is covered under standard 19.

Although there was a national Child and Youth Participation Strategy, participation of children in the development and delivery of the foster care service varied considerably between service areas. For example, some areas, Dublin North, Mayo and Sligo, Leitrim and West Cavan, were particularly progressive in looking at ways to ensure children's participation and they had a young person's participation group named 'Fora'. The service's management team had developed this group as part of a service improvement initiative to capture the voice of the child in their review meetings. The young people in Mayo advised they were working to review the care plan forms so as to make them more relevant to their needs and circumstances. In addition, staff had received training in a child participation model to support them to engage and help children. The Mayo Youth Participation Committee had developed a 'Staff Pack' for Tusla staff – a toolkit for practitioners on how to engage online with children and young people. Donegal also had a strong focus on the participation of children and parents and were continuously striving to develop this further. For example, in 2021, ten young people participated in a project to progress changes required to enhance the participation of children in child-in-care reviews. The area had won an 'investing in children' award in 2020 following a project completed with children and young people. In Dublin North, managers introduced 'care bags' to support children when they were admitted to care on foot of feedback from the group, and they also won an award.

Other service areas were, however, at the early stages of developing their services' participation forums. Staff had participated in training on the children's participation model, and while they demonstrated that children participated in their individual care planning by attending child-in-care reviews, they did not yet have formal mechanisms in place to promote their participation in the overall development of the foster care service. Better governance at a national level of each service area's progress in implementing the Child and Youth Participation Strategy may lead to more consistent and timely implementation of the strategy. In addition, the Strategic Plan for Foster Care Services for Children and Young People 2022-2025 identifies additional recommendations in order to improve participation and information sharing with children, parents and foster carers.

The process in place to ensure children and foster carers were kept up to date and informed about policies and procedures, such as their right to complain and how to do so, varied across service areas. Again, this raised questions about the national governance of this practice across Tusla service areas and regions. Children and

foster carers in some service areas told inspectors that they were kept very well informed about policies and procedures, and that they were aware of their right to complain and how to do so. The young persons 'Fora', that was operational in some service areas, made an effective contribution to policy and practice development through providing feedback on the service and developing leaflets about children's rights. In other service areas however, participation of children and foster carers in the development of the foster care service was not well developed, and required further improvement.

Working protocols between Tusla and relevant stakeholders, such as HSE Disability Services and An Garda Síochána, facilitated good practice for the management of specific cases, such as children with additional needs who were turning 18 years of age. In one area, however, the frequency of the meetings required improvement to ensure that children received a more timely response, and in others, meetings had been cancelled at the beginning of the COVID-19 pandemic. Nonetheless, a consistent finding from the thematic programme related to gaps in the availability of specialist services, such as play therapy and occupational therapy for some children, and autism assessments, which required further attention within joint agency forums. However, inspectors found that individual cases were escalated by seniors managers through the escalation process when required, or Tusla provided funding for the relevant service to be provided.

There was appropriate planning and good oversight for the majority of children in care who transferred between service areas. When the national transfer policy in relation to children being placed outside of the area was followed, there was evidence of good joint working between these service areas. However, in some areas, such as Dublin South Central, there were significant delays in transferring children to the service area where they were living, due to the pressures in those areas in relation to staff vacancies.

Examples of where good governance led to good practice included:

- a 'task and finish' group operated in the West region to drive consistency and promote learning across the region
- several areas demonstrated that they promoted a partnership approach with children, foster carers, and professionals
- implementing the national strategy on child and youth participation
- foster carers receiving information on policies from social work and business support teams
- joint visits taking place with link social workers and children's social workers
- discussion with regards specific standards at monthly meetings to build on team skills, knowledge and expertise.

Areas whereby governance required improvement included:

- there was inconsistent implementation of some policies, such as the complaints policy and supervision policy, and there was a lack of management oversight with regards the supervision of social care workers allocated to cases in the absence of a social worker
- several areas developed their own local policies and procedures to manage situations, which led to differing practice around the country. This meant that service provision for children and foster carers varied depending on what approach was taken by each service area.
- local procedures for the management on unallocated cases were not effectively implemented or standardised across teams, and this led to poor practice in two service areas in particular, Louth Meath and Dublin North
- some service areas required improvements in adherence to policies regarding the maintenance of case files, and foster care records, and the management of allegations made by children in care.

6.2. Standard 19: Management and monitoring of foster care services

Standard 19: Management and monitoring of foster care services

Health boards have effective structures in place for the management and monitoring of foster care services.

Judgment	No of Areas	Service Areas
Compliant	**0**	
Substantially Compliant	**5**	**Mayo** **Donegal** **Galway and Roscommon** **Dublin South Central** **Midlands**
Non-compliant Moderate	**8**	**Cavan Monaghan** **Sligo, Leitrim and West Cavan** **Louth Meath** **Carlow, Kilkenny and South Tipperary**

		Mid West **Dublin North** **Waterford and Wexford** **Dublin South East / Wicklow**
Non-compliant Major	**0**	

The leadership, governance and management arrangements in place should provide assurance at local, regional and national level that the service is meeting their legal requirement to protect children. The components of good governance include clear lines of accountability, good planning and decision-making and successful risk management, quality assurance and performance assurance systems, which are underpinned by effective communication among staff.

All service areas had clearly defined governance arrangements and structures in place. Each area had the management structures and reporting systems in place to encourage and support clear accountability and reporting. However, despite this, some service areas struggled with staffing capacity and resources to be able to fully manage and monitor the service they provided. In addition, reporting mechanisms in order to measure performance, through key performance indicators, and data analysis required improvements, and were impacted by poor data collection, and recording. As a result, of the 13 service areas inspected, none of them were compliant, eight were moderate non-compliant and five were substantially compliant in respect of management and monitoring of foster care services.

Service improvement plans were in place and service areas benefited from having strong, stable and experienced management teams. There was a focus on service improvement in all areas. In service areas with good governance they ensured that the provision of services was being informed by the voice of children and their experiences in foster care and service plans had been effectively used to promote improvements in service delivery. Each service area had strategic plans in place that were aligned to the Tusla national service plan. However, the effectiveness of services areas' plans was reliant on the capacity of the service areas to implement them in practice. Some service areas plans did not effectively identify and target some of the unique challenges and risks identified for foster care services in the previous 12 months.

The pace of overall service improvement was compromised by persistent shortfalls in the capacity of some service areas to meet demands. In 2021, the six service areas inspected had assessed themselves as having high levels of compliance. Five of the six service areas inspected had sufficient staffing to adequately deliver services. In the service area that had staffing vacancies, this had impacted on the quality and continuity of care and support for children and for foster carers. Some contingencies

to limit the impact of staff vacancies were effective, such as the foster care principal social worker undertaking social work team leader duties. Other contingencies, such as approval for filling a vacant post on a temporary basis, had not been effective, as the area had been unable to find a suitable candidate.

In 2022 however, the situation in the seven service areas inspected showed that staffing shortfalls had deteriorated since their self-assessment. All of these service areas had unallocated children in care, and some children were unallocated for long periods of time, with one service area in particular having a significant number of children who had experienced a very high level of social worker turnover.

There were failures in relation to the governance of unallocated children in care in three of these service areas. HIQA sought assurances in relation to these areas following each inspection and satisfactory assurances were provided by Tusla. One service area was requested to provide assurances in relation to the control measures they had identified to manage unallocated children in care as they were not fully implemented nor were they possible to implement. In another area, it was noted that they still had work to do to prevent reoccurrence of 'dual unallocated' children and foster carers; this is where neither the child nor the foster carers had an allocated social worker to oversee the placement. Work was also required to ensure that all children placed in non-statutory foster care placements had a Tusla allocated social worker to oversee their care. In a third service area, individual children in care cases were escalated due to the lack of management oversight of key statutory requirements such as visits to the children. Inspectors found there was not adequate oversight and governance by Tulsa at a national level as evidenced by the requirement for HIQA to escalate these risks and required assurances from Tulsa.

Effective risk management is critical to ensuring that the service is safe, and that areas of high risk are identified, managed and mitigated against. Many areas had experienced significant pressures as a result of staffing vacancies, the impact of COVID-19 restrictions and the cyber-attack[6]. As a result the numbers of unallocated children in care in service areas was rising. It was evident that COVID-19 also had an impact on the recruitment and retention of foster carers. Support services were closed and this put additional strain on placements. These issues along with staffing challenges meant that some children did not have a consistent social worker while residing in foster care. This is not in line with national standards.

Tusla has a risk management framework in place as mentioned under standard 18, and risks were escalated through the 'Need to Know' process. Despite risks being escalated by service areas in line with Tusla's national policy, some risks remained.

[6] In May 2021, Tusla experienced a 'cyber-attack' which made their national childcare information system, which is its biggest database, inaccessible.

Risks in relation to staffing vacancies, unallocated children in care and lack of placements to meet the needs of children were all risk escalated but the management response from the national office had not been effective. These remained areas of ongoing organisational risk at a national level which impacted on the services areas capabilities to provide a consistently high standard of safe, effective and child-centred care for all children in foster care. Governance of risks therefore from a national perspective required significant attention.

In December 2022, Tusla published its Strategic Plan for Foster Care Services for Children and Young People 2022-2025, and while HIQA welcomes this plan for improving the quality of the foster care service provided in the longer term, attention to the areas of greatest risk require a more immediate, urgent, dynamic response in the short term.

Effective quality assurance systems are an essential part of good governance. Service areas that are well governed regularly assess and evaluate the service delivered to children in foster care and their carers in order to improve services. This information provides assurance at local, regional and national level that a safe service is provided to children and families in line with the organisation's policies and procedures.

Although Tusla had a quality assurance directorate, improvements were required nationally in overseeing quality assurance systems across foster care services. The directorate promoted quality assurance primarily by audits conducted by Tusla's Practice Assurance and Service Monitoring Team, throughout the organisation by service areas. In addition, auditing was carried out by the service areas themselves.

Some service areas had better developed quality assurance systems than others, in that some service areas had more advanced and effective auditing activity. For example, in the Midlands service area the management team consistently monitored practice and service provision. There was a strong auditing culture and various audits had been completed across all areas of service provision. The service area had established systems in place for tracking performance, patterns and practice areas but some improvements were required to ensure all data was up to date. The service worked closely with Tusla's quality assurance team and the regional quality, risk and service improvement (QRSI) manager. The quality assurance officer attended audit meetings, tracked progress on actions required and outlined that learning was shared on findings on a regional basis. Some, but not all, service areas had a quality and risk service improvement officer.

The variance and inconsistent practice, however, that was evident throughout the 2021-2022 inspection programme, highlighted the lack of national oversight of quality assurance systems across all service areas.

Improvements in the case management systems were required to ensure managers had accurate, relevant, up-to-date data to provide oversight of key aspects of the service. Tusla's information management system — the National Child Care Information System (NCCIS) — was used to monitor service provision and identify learning. However, only children's files were saved on NCCIS and foster carers' files remained in paper format. Inspectors found that documents were not consistently uploaded onto NCCIS in a timely way. Documents were often difficult to locate as they were saved in different locations on the system, and naming conventions were not standardised. Some individual initiatives were put in place to address these issues, for example in Dublin North, funding for additional administration staff was secured in order to ensure data on NCCIS was accurate, and this had helped to address the backlog in case records awaiting uploading. When issues were identified, action plans had been developed to implement that learning. Examples of actions included the provision of training to enable better use of the monitoring function on the NCCIS.

Some improvements since previous inspections were noted in relation to the use of data, NCCIS, auditing, and management reviews, to inform the service areas' service improvement plans and initiatives. The impact of the cyber-attack earlier in 2021 was particularly challenging, and the move to working from home due to COVID-19, meant that ensuring that children's information was safe, up to date, and easily accessible became even more important. The majority of areas (nine out of the 13 service areas inspected) continued to struggle with ensuring information was recorded and documents were uploaded onto the system in a timely manner and in the right place. While improvements were noted in the use of standard names on NCCIS documents, such as visits with children and foster carers, and the use of templates — for example, for statutory visits — some variance in recording of case work was still evident. Consistent auditing of case records in particular therefore was an area for significant development.

In the 2022 inspections in particular, three out of the seven areas inspected identified gaps in case management and information management systems. This is turn meant that service areas could not always accurately report on performance in real time, and putting measures in place to mitigate against risks was therefore difficult, when the data was not fully reliable or up to date. Quality assurance activity in these instances, was not consistently leading to better practice at the time of these inspections due to pressures in capacity across the workforce. While service areas were striving to improve practice, some audits, for example, did not have an impact to improve service provision for children and foster carers.

At the time of writing this overview report, Tusla had successfully migrated from their NCCIS to a new integrated information system called Tusla Case Management

(TCM). HIQA inspections going forward will look at whether this has led to improved oversight and monitoring of children's cases and performance indicators, through more accessible data and information. Foster carers' records continue to remain paper based, which presents a difficulty when it comes to accessing information centrally or remotely and gathering data, such as the frequency and quality of supervision and support visits to foster carers.

Workloads and staffing resources were seen to have a direct impact on the quality and safety of the service provided, in particular throughout 2022. Many front-line practitioners had unmanageable workloads and were overstretched. In addition, managers' workloads had also come under increasing pressure as a result of having to manage teams which had front-line social worker vacancies. Inspectors' review of records indicated staffing pressures in some cases had impacted on the capacity of front-line staff and managers to maintain up-to-date case records or complete key projects within desired time frames. Many areas had tried to address these risks in a variety of ways, with varying success. One service area had approved the establishment of an additional team leader and social work posts and the reconfiguration of resources to enable the appointment of non-social work roles within front-line teams. New social work graduates had been attracted to work in some services. One service area had developed a joint approach with another service area to encourage better community awareness of fostering. In one service area which was particularly challenged by high level of vacancies and significant numbers of unallocated children in care, managers were seeking to achieve better value from local resources through partnership working and sharing of expertise. Inspectors found some examples of well-established relationships with community and voluntary sector organisations that promoted innovative practice, in order to support them in managing the risks. However, these findings indicate that a national approach for the management of staffing deficits and shortfalls, and the oversight of unallocated children in care is urgently required, to ensure better monitoring of the quality and safety of the service provided to these children.

Additional areas requiring improved governance noted throughout the inspection programme, included the management of child protection and welfare concerns (for children in foster care), the management of unallocated foster carers, and the tracking and oversight of statutory visits to children in care and supervisory visits to foster carers. Improvements were also required in relation to systems for oversight of the placement of children with relative foster carers.

Examples of where good governance led to good practice included:

- Clearly defined governance structures
- All areas had service improvement plans

- Some service areas had good-quality assurance measures in place and were undertaking regular audits.

Areas whereby governance required improvement included:

- Staffing vacancies meant that service areas did not have the capacity to meet the demands of the service
- Ensuring that there were no dual unallocated cases, or children placed with non-statutory agencies with no oversight by a Tusla social worker
- Control measures to manage unallocated cases were not always effective
- There was no national oversight of quality assurance mechanisms throughout the 13 service areas
- The auditing of case records on a consistent basis
- The urgent need for a national approach to management and oversight of unallocated children in care.

6.3: Standard 20: Training and qualification

Standard 20: Training and qualification

Health boards ensure that the staff employed to work with children and young people, their families and foster carers are professionally qualified and suitably trained.

Judgment	No of Areas	Service Areas
Compliant	**2**	**Donegal** **Dublin South East / Wicklow**
Substantially Compliant	**11**	**Mayo** **Cavan Monaghan** **Sligo, Leitrim and West Cavan** **Galway and Roscommon** **Dublin South Central** **Louth Meath** **Waterford and Wexford** **Carlow, Kilkenny and South Tipperary** **Mid West** **Midlands** **Dublin North**
Non-compliant Moderate	**0**	
Non-compliant Major	**0**	

There was a high level of compliance across all service areas regarding this standard, with two service areas being fully compliant, and 11 service areas substantially compliant.

All areas had systems and processes in place to ensure that staff were safely recruited in line with legislation, standards and policy. Staff were suitably qualified, trained, and had the required registration and An Garda Síochána vetting completed. All areas had various systems, such as monthly checks in place, to ensure that the relevant checks were kept up to date.

Overall, some improvements were required in relation to the governance of staff files. For example, there were some gaps in information on staff files such as references or qualifications not being held on staff personnel files. This meant there was no direct oversight by management of the qualifications of staff who were working with children and their families. There were multiple systems in place; some staff files continued to be held by the HSE, some records were held regionally by Tusla, and some were held nationally. The impact of multiple systems meant that there were gaps in records as they were not all held together. These gaps were brought to the attention of managers during the various inspections and assurances were provided that all documents were accounted for.

Many areas struggled to recruit staff due to a shortage of social workers at a national level. While some areas experienced a low turnover of staff, the majority of service areas experienced issues with retention. Service areas were proactive and put initiatives in place, such as promoting further education and training and having wellbeing programmes in place, some of which included access to wellbeing videos which were available to staff during the COVID-19 pandemic.

There were comprehensive induction programmes in place for new staff, which included a corporate induction, and local initiatives were also found, such as mentoring of new staff, increased supervision, and support to engage in further training opportunities.

Staff were supported and encouraged to engage with Tusla's 'Empowering Practitioners in Practice' (EPPI) programme. EPPI was developed to help bring greater consistency and to improve the use of evidence across social work practice. Managers were encouraged to engage with leadership training. Various local initiatives were in place such as developing a caring work culture through best practice, discussing wellbeing at team meetings, and staff retention groups being developed to increase retention in areas. Staff in many of the service areas reported a culture of learning and valued the support provided by their managers.

One of Tusla's national goals in its Annual Report for 2022 was to ensure that staff and leaders were empowered to continuously learn and improve so that children,

families and communities benefitted from the service. Some of the training provided included risk management, data protection, attachment and a child's participation model to support children's views being taken into consideration. There were various e-learning modules also available to staff through a Tusla national online hub. This meant that training sessions were widely available to staff and increased the availability of training to staff. While some service areas had developed training needs analyses to inform their learning and development programmes, some were not up to date and professional development plans were not always in place for staff to promote their learning needs. Senior managers acknowledged the requirement to enhance this in certain service areas to further add to the retention initiatives which were in place for staff.

Overall, the majority of areas had supervision in place that met the requirements of the national policy to support staff. Some improvements in the supervision process were required and these included ensuring the frequency of supervision in some areas was in line with Tusla policy, ensuring good records were maintained, and that actions and decisions were tracked from one session to another. Improved national oversight of supervision processes would assist in promoting best practice and good oversight of the work undertaken by social workers with children and their families.

Examples of where good governance led to good practice included:

- Development plans for staff were in place
- Strong joint working between frontline staff and external professionals
- Staff were well supported, supervised and there was a strong culture of learning
- Innovative commissioning practice and inclusion of culturally diverse communities by the Cavan Monaghan service area
- Well-established joint training programme with the local universities in some areas.

Areas whereby governance required improvement included:

- Ensuring accurate and contemporaneous staff records were maintained
- Continued promotion of joint training between social workers and foster carers
- The quality of supervision records
- The consistent use of training and development plans
- Ensuring the regular occurrence of supervision in line with Tusla's national policy.

6.4: Standard 21: Recruitment and retention of an appropriate range of foster carers

Standard 21: Recruitment and retention of an appropriate range of foster carers

Health boards are actively involved in recruiting and retaining an appropriate range of foster carers to meet the diverse needs of the children and young people in their care.

Judgment	No of Areas	Service Areas
Compliant	**1**	**Galway and Roscommon**
Substantially Compliant	**5**	**Mayo** **Donegal** **Carlow, Kilkenny and South Tipperary** **Midlands** **Dublin North**
Non-compliant Moderate	**7**	**Cavan Monaghan** **Sligo, Leitrim and West Cavan** **Dublin South Central** **Louth Meath** **Waterford and Wexford** **Dublin South East/Wicklow** **Mid West**
Non-compliant Major	**0**	

Recruiting foster carers has been a significant challenge for Tusla throughout 2021 and 2022 due to a number of factors, including COVID-19. Throughout this thematic programme, the lack of a sufficient range and number of foster carers was particularly evident. While one area was compliant with this standard, five were substantially compliant and seven were non-compliant moderate.

With the exception of one service area, improvements were required in how Tusla recruited and retained an appropriate range of foster carers in all of the other twelve service areas. Despite service areas having a strategy for the recruitment of foster carers that was aligned to Tusla's national recruitment campaigns, there was a lack of suitable foster care placements for children requiring an admission to care.

The processes in place for the recruitment of foster carers varied across the service areas and regions. In the Dublin North East and Dublin Mid Leinster regions there was a specific team named the Regional Assessment Fostering Team (RAFT). RAFT were responsible for the recruitment and assessment of carers in the service areas in these regions. Despite having this dedicated resource, RAFT did not recruit and

assess a bigger number of foster carers, than those service areas who did not have this dedicated team. One service area decided at the end of 2021 to develop and implement their own recruitment plan. In the other regions, where service areas themselves carried out this work, they were often more successful.

RAFT had only approved two foster carers for one region in the preceding 12 months. This was in contrast to another service area that recruited and assessed its own foster carers, who despite the challenges with COVID-19 and staffing, had successfully recruited and assessed 15 foster carers in the preceding 12 months.

All areas sought to assess suitable relatives as foster carers in the first instance, with the percentage totals of relative foster carers out of all foster carers varying between 13.5% in one service area to 36% in another.

Responsiveness to enquiries to become foster carers was found to be good in all the areas inspected. The systems in place in some areas to ensure timely approval of relative carers required improvement, and gaps in staffing capacity contributed to this delay. The gaps in staffing capacity meant that all areas struggled to complete foster care assessments in a timely manner. The lack of staffing, therefore, had a direct impact on service areas' ability to assess and approve more foster carers. The knock-on effect of this was that they continued not to have enough foster carers to meet the demand. While one service area had completed an evaluation of their recruitment drive, they were unable to make any progress as they lacked the staffing capacity to complete assessments.

Placing children within their own communities is considered best practice where possible, as they can generally remain attending the same school, and maintain links with family, friends and their community. In 2021, inspectors found that only two of the six service areas inspected had placed children outside of their area. Given the challenges with recruitment, this was a positive achievement. Unfortunately, findings from the 2022 inspections found that, due to the lack of foster care placements, the matching process was impacted upon for some children and this meant that some children were not placed within their own communities. Where children were then placed with general foster carers, overall there were comprehensive matching processes that sought to place children in their own community. Again, however, processes were not consistent. There were gaps in some areas due to the lack of available placements, Dublin North and Waterford Wexford in particular, and given the lack of national oversight of the matching processes in all areas, one area, Louth Meath, had recently implemented a local strategic approach by adopting a local arrangement for recruitment, assessment and matching.

In the areas where RAFT was in place, there was a regional matching process, which meant that children could be placed with foster carers living in different counties.

There were mixed findings in relation to the evidence of the matching process, with some files containing good evidence of matching children with foster carers, while others had no evidence of how children were matched. However, one area had completed an audit about matching and then made recommendations, such as needing to complete written matching tools and placement request forms in a timely way.

Due to not having enough foster carers to meet demand, some children were placed in non-statutory foster placements or were waiting for a suitable match. Some children were placed with carers who already had too many other children placed with them. This was not in line with the regulations, which state that no more than two unrelated children should be placed at any one time. One area, for example, had 14 foster placements where the number of children placed exceeded what is recommended (two unrelated children), 21 children were placed in non-statutory placements and 13 children were waiting for a suitable placement. Another area had 47 children placed in non-statutory placements. The lack of placements to meet demand had an impact on the ability of service areas to match children appropriately.

Good practice was found in all of the service areas inspected in relation to the practice of offering exit interviews to foster carers who had left the panel, to inform service improvements. All areas offered exit interviews to foster carers, which gave the foster carers the opportunity to give feedback in relation to their experience of the service, and for those who volunteered to participate in them, they were arranged in a timely manner. In some areas, the foster care committee analysed the exit interviews for learnings, and this was an example of good practice. In some service areas where the uptake of exit interviews was low, alternative ways of capturing feedback, outside of the exit interview process, were being considered. Changes on foot of findings from exit interviews were not always evident, since reasons for leaving were often due to foster carers retiring, leaving on health grounds, or the children ageing out of care, with some foster carers indicating communication difficulties, or a lack of support.

Examples of where good governance led to good practice included:

- In Mayo, all children had an allocated social worker and all foster carers had an allocated link worker
- There was good recognition of children's faith, culture and ethnicity within the recruitment, assessment and matching processes
- Effective systems to analyse their recruitment campaigns and identify service needs
- Clear and effective matching policies and processes

- Inclusion of foster carers and young people with care experience in recruitment campaigns
- Recognition of the impact on birth children of foster carers and giving consideration to the impact on the family as a whole.

Areas whereby governance required improvement included:

- Learning from the review of exit interviews
- The recruitment and assessment of carers for an identified cohort of children with specific needs
- Approval of long-term placements
- Lack of foster care placements nationally
- Timeliness in completing foster care assessments at the recruitment stage.

6.5: Standard 22: Special foster care

Standard 22: Special foster care

Health boards provide for a special foster care service for children and young people with serious behavioural difficulties.

Judgment	No of Areas	Service Areas
Compliant	**0**	
Substantially Compliant	**12**	**Mayo** **Cavan Monaghan** **Sligo, Leitrim and West Cavan** **Donegal** **Galway and Roscommon** **Dublin South Central** **Louth Meath** **Mid West** **Midlands** **Dublin North**
Non-compliant Moderate	**1**	**Carlow, Kilkenny and South Tipperary**
Non-compliant Major	**0**	

This standard required Tusla to have a policy and procedure to support the care provided to the particular needs of children with behaviours that challenge. However, Tusla did not have any national policy in place to support service areas' compliance with this standard resulting in variations in practice across the country.

In the absence of a national policy and various levels of access to additional supports, no service area was deemed compliant with this standard. The absence of a national policy meant that there was an inequality of access to additional services through completing assessments of need for children. This meant that access to additional supports for children and foster carers very much depended on actions and local policies in each area rather than all having access to the same supports regardless of where they lived. A consistent national approach in meeting this standard is required to ensure equitable access to a foster care service that meets their needs.

Despite this, positively in 12 of the 13 service areas inspected, inspectors found that additional supports for foster carers who were caring for children with complex needs were provided. These supports were provided through locally developed policies in the absence of a national policy. The supports varied from additional payments to cover medical costs, or additional support in the form of respite, training, and access to therapeutic services.

In the one service area that was deemed non-compliant with this standard, the process for accessing additional supports was complex. This meant that children and their foster carers were often waiting excessively long periods of time to access these additional supports in comparison to other service areas.

HIQA highlighted the inconsistent approach to Tusla who indicated that they were seeking to promote consistency in their approach to the provision of foster care to children with complex needs, and the provision of services to better support their foster carers. Tulsa demonstrated some progress toward the latter part of 2022, through piloting their own internal multidisciplinary teams which reflected Tusla's Strategic Plan for Foster Care. Tusla's strategic plan, published in June 2022, includes a recommendation that the potential for a tiered fostering service be explored, to support more vulnerable children, the time frame for which is Q4 2023.

Examples of where good governance led to good practice included:

- Tusla funding of additional specialist services when required
- The recognition of gaps in service provision and appropriate steps taken to support and manage enhanced placements
- The assessment of people assessed within the foster carer's own network who had a significant relationship with children to provide respite care
- Consultation with a range of professionals in relation to children's care and needs
- Referrals were made to specialist services where needed
- Some support services were privately funded by Tusla when public services could not meet the needs of children.

- The Midlands service area had been chosen as the regional pilot site for an 'integrated therapy team'.

Areas whereby governance required improvement included:

- The development of a national policy in relation to providing a special foster care service for children with complex needs as required by the standards and to provide clear guidance in the provision of a special foster care service for the cohort of children that required this service
- The requirement for national approach to the governance and oversight of special foster care arrangements
- Equal access to supports for special foster care arrangements regardless of where children and foster carers reside in the country
- The provision of regular respite placements, and reduction in waiting lists for respite placements.

6.6: Standard 23: The foster care committee

Standard 23: The foster care committee

Health boards have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards' policies, procedures and practice.

Judgment	No of Areas	Service Areas
Compliant	**4**	**Sligo, Leitrim and West Cavan** **Donegal** **Galway and Roscommon** **Midlands**
Substantially Compliant	**7**	**Mayo** **Cavan Monaghan** **Dublin South Central** **Louth Meath** **Carlow, Kilkenny and South Tipperary** **Dublin South East/ Wicklow** **Dublin North**
Non-compliant Moderate	**2**	**Mid West** **Waterford and Wexford**
Non-compliant Major	**0**	

The findings in relation to this standard were varied across the service areas inspected, with four areas in full compliance with the standard. Seven service areas were substantially compliant and two service areas were non-compliant moderate with this standard. Due to poor governance and oversight in some areas as well as poor monitoring at a national level, some areas were not meeting the requirements of Tusla's national policy and the *National Standards for Foster Care* (2003).

The *National Standards for Foster Care* (2003) require that Tusla have foster care committees in place in order to:

- Consider assessment reports and make recommendations and appropriate approvals regarding foster carers
- Approve long-term placements of over six months duration
- Review the approval status of foster carers after foster care reviews
- Contribute to the development of policies, procedures and practice.

Therefore, the foster care committee has a key governance function in ensuring that children are placed in safe and appropriate foster care placements with foster carers with the appropriate skills.

All service areas had a foster care committee that was made up of members in line with Tusla's Foster Care Committee Policy. They were all chaired by an experienced independent chairperson, with the exception of Carlow Kilkenny South Tipperary. Due to the continued absence of the chairperson, this service area had to put alternative arrangements in place. However, the alternative was not independent of the service, as required by the policy. In this area, other non-compliances were also found as a result of the challenges faced by the service area in the previous 12 months. There was a backlog of reviews being heard by the foster care committee, and disruption reports were not being presented to the committee.

In the Midwest area, governance of the foster care committee was lacking, as the service area had failed to ensure the safe approval of foster carers by the foster care committee. In this area, foster carers had been approved without evidence of the required training in Children First. This was escalated to the service area at the time of inspection, as it is a legal requirement under the Children First Act 2015. Assurances were provided by Tusla that appropriate measures were taken by the area to change this practice going forward.

In the main, all members of the foster care committees were appropriately vetted, their references had been sought, and their qualifications were on file. There were some improvements required relating to the maintaining of foster care committee members' records as this was varied between service areas. The impact of this was that not all managers had access to committee members training, vetting and

qualifications to ensure they were meeting the national requirements for committee members, and to ensure they had oversight of vetting requirements. In the latter part of 2021, Tusla encountered an issue with the timely Garda Síochána (police vetting) of committee members, however they had appropriately escalated this issue to An Garda Síochána.

Foster care committees operated in line with the policy for the most part, with a few exceptions as already noted, and all had access to relevant expertise, such as medical advice, when required. Minutes of meetings were detailed, and recommendations and decisions were well documented.

There were good reporting arrangements in place between foster care committee chairpersons and the service areas, either to the area manager or their equivalent.

Examples of where good governance led to good practice included:

- Evidence of induction for foster care committee members
- Joint development work with other foster care committee chairs
- Planning to address backlogs of foster carer review reports.

Areas whereby governance required improvement included:

- Addressing the backlog of foster carer reviews
- Presenting disruption reports in a timely manner
- Ensuring foster care committee members personnel files were maintained and of good quality
- Ensuring that the chairperson was at all times independent
- Ensuring foster carers were trained in Children First (2017) prior to their approval.

6.7: Standard 24: Placement of children through non-statutory agencies

Standard 24: Placement of children through non-statutory agencies

Health boards placing children or young people with a foster carer through a non-statutory agency are responsible for satisfying themselves that the statutory requirements are met and that the children or young people receive a high-quality service.

Judgment	No of Areas	Service Areas
Compliant	**2**	**Midlands** **Waterford andWexford**
Substantially Compliant	**9**	**Cavan Monaghan** **Sligo, Leitrim and West Cavan** **Donegal** **Galway and Roscommon** **Dublin South Central** **Louth Meath** **Carlow, Kilkenny and South Tipperary** **Mid West** **Dublin North**
Non-compliant Moderate	**1**	**Dublin South East/Wicklow**
Non-compliant Major	**0**	

By the end of this inspection programme, service-level agreements were in place with all non-statutory foster care agencies in Ireland. However, one service area, Dublin South East Wicklow, did not have a service level agreement with a non-statutory foster care agency outside of Ireland. Two areas were compliant, nine were substantially compliant and one area was non-compliant moderate with this standard. No children in Mayo were in non-statutory placements; therefore this standard was not reviewed for the Mayo service area.

In 2021, five of the six service areas inspected placed children in non-statutory placements provided by private foster care agencies, yet Tusla had no service-level agreement in place for these arrangements. At the time, Tusla's national office was in the process of agreeing contracts with all private foster care agencies, which was to include a service-level agreement. This had been delayed due to the cyber-attack earlier in the year. Therefore, for this reason, all five service areas were judged to be substantially compliant. In 2022, service-level agreements were put in place with all non-statutory foster care agencies in Ireland. Also, at the start of 2022, a new protocol for the governance of non-statutory foster care agencies was implemented by Tusla. The role of governance and oversight of service provision was delegated by Tulsa to two national managers, and the protocol set out Tusla's governance arrangements for all non-statutory agencies. A Tusla national manager met with the non-statutory agencies every quarter and reported to the regional chief officer in relation to this.

For the most part, all areas ensured that children in non-statutory placements were allocated and that all statutory visits were completed in line with regulations, and

that care plans and child-in-care reviews were up to date. There were some examples where this was not the case. This meant that Tusla had no direct oversight of the care being provided to these children. One service area had put in a tracking system to ensure that statutory work for all children placed in non-statutory agencies was undertaken, which was an example of good oversight.

Improvements were required in one service area, Dublin South East/Wicklow, in particular in order to bring it into full compliance. In this service area, one of the children placed in non-statutory foster care did not have an allocated social worker for the three months prior to and also at the time of the inspection. This was not in line with the national standards and also meant that Tusla had no direct oversight of this child. In addition, this service area did not have a service-level agreement in place for a foster care provider outside of the State, and finally, the names of foster carers living in their area were not on their local foster care panel, which was not in line with statutory requirements

Local service area foster care committees ensured the assessment, review and approval arrangements for foster carers assessed by non-statutory agencies complied with the standards set out in the foster care committee policy, procedure and practice guidelines.

Examples of where good governance led to good practice included:

- Good communication between foster carers in maintaining contact between siblings who were not living together
- Oversight of the quality of foster care included recognition of their accountabilities for reporting child protection concerns, promoting children's identity and relationships with their birth family
- The Donegal area requested that non-statutory foster care services complete a self-audit, to provide assurances with regard to Garda vetting, Children First mandatory training, and adherence to policies in the absence of a national service agreement at that time
- Private foster carers were reviewed through the foster care committee to ensure that assessment and review arrangements for non-statutory foster care agencies complied with the standards set out in policy, procedure and practice guidelines for the management of its foster care panel
- Social workers had good oversight of the support and supervision provided to foster carers
- Good communication between the child in care social worker and the non-statutory agency fostering link worker which showed good collaborative working between both services in order to promote the quality of care provided to children.

Areas whereby governance required improvement included:

- Not all children living in non-statutory foster care had an allocated social worker. This meant that the quality of children's care in non-statutory foster homes was not always supervised by a Tusla social worker in accordance with best practice.
- There were some delays in statutory visits, child-in-care reviews and with managers signing off on documents.

6.8: Standard 25: Representation and complaints

Standard 25: Representation and complaints

Health boards have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fide interest in their welfare can make effective representations, including complaints, about any aspect of the fostering service, whether provided directly by a health board or by a non-statutory agency.

Judgment	No of Areas	Service Areas
Compliant	**4**	**Mayo** **Sligo, Leitrim and West Cavan** **Dublin South Central** **Dublin North**
Substantially Compliant	**8**	**Cavan Monaghan** **Donegal** **Galway and Roscommon** **Louth Meath** **Waterford and Wexford** **Dublin South East/Wicklow** **Mid West** **Midlands**
Non-compliant Moderate	**1**	**Carlow, Kilkenny and South Tipperary**
Non-compliant Major	**0**	

There were good levels of compliance found in relation to this standard with four areas being fully compliant and eight service areas judged as substantially compliant. One area was assessed as non-compliant moderate. The majority of complaints about foster care services related to matters such as permanency

planning for children, communication and access, and children not having an allocated social worker.

The 12 service areas judged as compliant or substantially compliant had good systems in place to ensure children, parents and foster carers were aware of how to make a complaint and were supported to do so when required. The majority of the service areas ensured that children and foster carers were also aware of the national advocacy organisations that were in place, which provided independent advocacy to service users.

Areas of good practice were found in these service areas:

- In Sligo, Leitrim, West Cavan and Donegal, external reviews of complex complaints resulted in learning and changes to practice such as developing a participation strategy to enhance communication with service users.
- Dublin South Central had provided the services of a mediator when required, in addition to the complaints officer, as a support to resolve complaints. Children were provided with an information pack when they came into care, which included information on how to make a complaint.
- There was evidence of creative initiatives to enable children and their families to make representations in two service areas about their experiences of foster care. For example, there was a peer mentoring group comprising of young people accessing aftercare services and another area had a children's fora.

Most areas tracked compliments as well as complaints. This information was discussed at senior management meetings which meant that managers were aware of the issues for service users as well as acknowledging the areas of good practice.

Minor improvements were required in relation to the recording of complaints. These related to ensuring consistency in how each area tracked and recorded complaints, including their outcomes, whether the complainant was satisfied or not, and if not whether they had been informed of the appeals process.

The service area which was non-compliant did not manage complaints in line with national policy. Areas for improvement included managing complaints in a timely way, as they had 16 complaints which remained open for more than six months, three of which remained open for more than 12 months. Letters had been sent to the complainants, in line with Tusla's procedures, advising them of the need to seek further extensions of time. In contrast with the other service areas, complaints were not routinely discussed in area management meetings. This meant that senior management did not have oversight of complaints in the service area.

The service area which was non-compliant also had a significant number of children in care without an allocated social worker. This meant those children did not have a known social worker with whom they could raise complaints.

Examples of where good governance led to good practice included:

- an open culture where children's rights and advocacy were strongly promoted and good relationships with external advocates.
- external/peer review of complex complaints to provide further assurance of an open and fair process, which provided challenge and support for changes to practice and wider organisational learning
- commitment to learning from complaints and endeavouring to resolve them at local level in the first instance, where possible.

Areas whereby governance required for improvement included:

- enhancing complaint trackers to ensure they are kept up to date and to also include additional required information such as if complainants were satisfied with the outcome
- ensuring children's files and foster carer files record that they were provided with information regarding the complaints procedure
- some areas did not have a formal system in place to monitor and track the issues raised by children during statutory visits.

7. Conclusion

Overall, the efficacy of governance arrangements at service area level was directly impacted by the ability of those service areas to manage their risks effectively, within their own capacity. The impact and success of service improvement plans and quality improvement plans was also directly impacted by the service areas' capacity to successfully implement their plans. Those service areas where risks were low, managed to successfully implement their service improvement plans and drive continuous improvement in their areas. In addition, it was found that service areas with lower risk were better able to provide oversight and governance which led to better practice in these areas. However, in service areas where risks were found, despite good governance at a service area level, they were unable to successfully manage or mitigate against the risks within their own existing resources. While many service areas put in place factors to mitigate against these risks, such as allocating social care workers to children in care, there was no overarching national response or oversight of these arrangements.

The absence of an effective strategic response to risks at a national level meant that inspections were highlighting recurrent findings in these areas with similar risks. Tusla had set up a specific forum in which to discuss national risks and findings, entitled the National Operations Risk Management and Service Improvement Committee (NORMSIC), however its effectiveness was not yet evident.

As the programme progressed, it became evident that there was a lack of a strategic approach by Tusla at a national level to oversee and put measures in place to manage risks.

HIQA identified that there is a need for a more consistent approach to the sharing of learning. This programme found that some service areas, such as the Midlands, Dublin South Central and Mayo had strong auditing culture, and local audits were carried out on a regular basis, and the learnings shared. This type of self-auditing is the first line of defence in identifying gaps and addressing them promptly. However, other areas lacked this, and gaps were found during inspection as a result. For example, assurances were requested following the Mid West inspection, due to significant gaps found on foster care files, which had they been routinely audited would have been picked up locally by the service area.

Greater oversight by Tulsa at a national level is required to avoid local policy and practices. As outlined during previous inspection programmes, local policies and procedures were developed, with many areas using already sparse resources to develop tracking systems and SOPs for the management of waiting lists, when these had already been developed in other service areas. The lack of quality assurance at

a national level was evident, and it was difficult to establish why service areas with higher levels of risk were not being prioritised for auditing by Tusla themselves to provide assurances to the national office.

Improvements were required to the management of risk. While risk management structures were in place, and being utilised by service areas, they did not lead to any significant effective response from the national office, as was evidenced by the further deterioration in some service areas since these inspections were completed.

Over the course of the last two years, there has been a lack of sustained improvement in specific service areas. Due to these concerns, HIQA will be taking a provider approach going forward into 2024, focusing on the provision of both Child Protection and Welfare and Foster Care Services, over the course of 14 months. This will include both children awaiting child protection and welfare services and also unallocated children in foster care.

The overall aim in carrying out an inspection at provider level, is to improve compliance and reduce waiting lists. The criteria for the programme will include any service area which has 25% or over unallocated children in foster care or open to the child protection and welfare service. A composite report on the findings of this approach will be published during and at the end of the programme

8. Appendices

Appendix 1 — Thematic inspections by service area

Service area	Inspection dates
Mayo	04-8 May 2021
Sligo, Leitrim and West Cavan	17-21 May 2021
Dublin South Central	22-26 November 2021
Dublin North	28-31 March 2022
Cavan Monaghan	29-30 November 2021 & 1-2 December 2021
Donegal	18-21 October 2021
Galway and Roscommon	01-4 November 2021
Louth Meath	24-27 January 2022
Waterford and Wexford	30 May-2 June 2022
Dublin South East/Wicklow	16-19 May 2022
Mid West	15-18 August 2022
Midlands	22-26 August 2022
Carlow, Kilkenny and South Tipperary	27-30 June 2022

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Appendix 2 — Members of the Expert Advisory Group

The Expert Advisory Group which informed this inspection programme comprised representatives from:

- The Child and Family Agency (Tusla)
- The Department of Children, Equality, Disability, Integration and Youth
- EPIC Empowering People in Care (an advocacy organisation for children in care and care leavers)
- University College Cork
- IFCA Irish Foster Care Association (an advocacy organisation for foster carers)

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